Payroll deduction will begin in the [ ] pay period.

☐ New Enrollee
☐ Beneficiary Change
☐ Dependent Update

LIFE & ACCIDENTAL DEATH & DISMEMBERMENT ENROLLMENT FORM
NASA EMPLOYEES BENEFIT ASSOCIATION

LAST NAME	FIRST NAME	INITIAL	POLICY NO. GL - 661 GD - 661	EFFECTIVE DATE / /
RESIDENCE NO. & STREET	CITY OR TOWN		STATE	ZIP CODE
SOCIAL SECURITY NUMBER - -	Org. Code	Phone Numbers	Home: ( ) Work: ( )	

FULL NAME (MARY A. DOE NOT MRS. JOHN P. DOE) AND RELATIONSHIP

Primary Beneficiary of Employee

Secondary Beneficiary of Employee

Subject to the provisions of the Group Policy issued by Alta Health & Life Insurance Company (Alta) , please furnish me with the insurance for which I am or may become eligible as a member of NASA Employee Benefit Association for which membership application is hereby made. My beneficiary is designated above. I understand that, unless I request otherwise, I am the beneficiary of any dependent's life insurance which may become effective. I hereby authorize a deduction from my paycheck to pay for my NEBA insurance.

Date _____ Signature of Employee _____

Do you wish to insure your eligible spouse?	CENTER LOCATION (AND MAIL CODE)	DATE EMPLOYED	DATE OF BIRTH
☐ Yes ☐ No*		/ /	/ /

*__Note to New Employees:__ *Even if you do not elect Spouse Coverage, your dependent children (14 days - 19 years) are automatically insured. Complete the area below.*

For NEBA Members who elect Spouse Coverage or who have children over 14 days but under 19 years.

	Name	*Date of Birth*	*Relationship*
Spouse:			Spouse
Children under 19:			

For use of NEBA Secretary-Treasurer and Payroll Office:

Basic: ☐ (Y or blank) **Spouse:** ☐ **Optional Units:** ☐ (1 - 10 or blank) **Smoker:** ☐ (Y or blank)

REMARKS:

GPO-393-11048 (2/00)

SUBJECT TO PRIVACY ACT OF 1974, WHEN NOT UNDER THE CONTINUING CONTROL AND SUPERVISION OF A PERSON WITH AUTHORIZED ACCESS TO THIS MATERIAL, IT MUST BE, AT A MINIMUM, MAINTAINED UNDER LOCKED CONDITIONS.